Maryland
BPQA
NEWSLETTER

Maryland Board of Physician Quality Assurance
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FEDERAL AND MARYLAND HEALTH CARE PRACTITIONER SELF-REFERRAL STATUTES

by: Michael D. Smith

Both the United States Congress and the Maryland legislature have recently enacted broad prohibitions against health care practitioners referring patients to entities with which they have financial relationships. These statutes require health care practitioners in many cases to either cease referrals to such entities or divest themselves of financial relationships with those entities. The Maryland statute also requires health care practitioners to disclose such financial relationships to their patients, and in most cases these disclosure provisions apply even if the referrals themselves are not prohibited.

FEDERAL "STARK" STATUTE

The federal statute is commonly referred to as the "Stark" statute after its author, Representative Fortney K. "Pete" Stark. The Stark statute was originally enacted by the United States Congress as part of the Omnibus Budget Reconciliation Act *("OBRA") of 1989 and significantly expanded by* OBRA of 1993. The Stark statute prohibits a physician from referring patients to entities with which he or she or an immediate family member has a "financial relationship," which includes both investment interests and compensation relationships.

The Stark statute presently covers referrals for clinical laboratory services payable under Medicare, but effective January 1, 1995, will cover referrals for a much longer list of "designated health services" payable under Medicare or Medicaid. The statute's list of "designated health services" consists of: clinical laboratory services, physical and occupational therapy, radiology and other diagnostic services, radiation therapy services, durable medical equipment, parenteral and enteral nutrients, equipment and supplies, prosthetics, orthotics and prosthetic devices, home health services, outpatient prescription drugs, and inpatient and outpatient hospital services.

The possible consequences of violation of the *Stark statute include denial of Medicare and Medic*aid payment for such services (including refunds of

claims improperly paid), civil monetary penalties and exclusion from the Medicare and Medicaid programs.

MARYLAND PATIENT REFERRAL STATUTE

The Maryland legislature passed the Maryland Patient Referral Statute ("MPRS") in 1993. The MPRS contains a referral prohibition which in several ways is broader than the federal Stark statute. The MPRS goes beyond the "designated health services" of the Stark statute to cover referrals to any "health care entity." The MPRS not only prohibits certain referrals made by physicians, but prohibits physicians and other health care practitioners from making or directing an employee or other person under contract to make such referrals. The MPRS applies not only to services paid for by Medicare and Medicaid, **but to services paid by any source, including private insurance.**

Violation of the MPRS referral prohibition would subject a health care practitioner to denial of payment (including possible repayment of claims improperly paid) and discipline by the appropriate licensing board. A health care practitioner who knows or has reason to believe that there has been a prohibited referral must disclose that fact on each request for payment or bill submitted to a third party payor.

EXCEPTIONS TO THE REFERRAL PROHIBITIONS IN EACH STATUTE

There are a number of exceptions to the referral prohibitions in the Stark statute and the MPRS which are set out in each statute but are too numerous to describe in detail here. It should be noted that the exceptions in each statute are **not identical**. Therefore, if an arrangement falls within the scope of both the Stark statute and the MPRS, the arrangement would be prohibited unless it meets exceptions in both of the statutes. In addition, meeting an exception to one or **both** statutes does not indicate that an arrangement complies with other federal or state laws.

PATIENT DISCLOSURE REQUIREMENTS CONTAINED IN THE MPRS

The MPRS requires a health care practitioner to make certain disclosures to patients of his or her financial relationships with entities to which he or she refers patients. Significantly, a health care practitioner in most cases must comply with these patient disclosure provisions **even if he or she meets an exception to the MPRS' referral prohibitions or is not yet subject to the referral prohibitions because of the grandfather provision described below.**

A health care practitioner must place on permanent display in his/her office a written notice disclosing all health care entities in which the practitioner or anyone in his or her immediate family owns a beneficial interest and to which the practitioner refers patients. The health care practitioner must also document in the medical record of the patient that a valid need exists for the referral and that the practitioner has disclosed to the patient the existence of the practitioner's beneficial interest.

For any referrals other than oral referrals by telephone, the health care practitioner must also provide the patient with a written statement that discloses the practitioner's beneficial interest and states that the patient may choose to obtain the health care services from another health care entity. The patient must then acknowledge in writing receipt of the statement, and a copy of that written acknowledgement must be placed in the patient's medical record.

Violation of the disclosure requirements of the MPRS subjects a health care practitioner to criminal misdemeanor penalties and discipline by the appropriate licensing board.

EFFECTIVE DATES OF THE STATUTES

Many of the provisions of these statutes are already in effect or will go into effect in the near future. The MPRS' disclosure provisions are already in effect for every health care practitioner

covered by such provisions (since October 1, 1993). If the health care practitioner had a beneficial interest in or compensation arrangement with a health care entity before January 1, 1993, and referrals to that entity would be prohibited by the MPRS, the health care practitioner must dispose of that interest or cease referrals by **March 15, 1997**. However, if the beneficial interest or compensation arrangement began after January 1, 1993, the health care practitioner was required to dispose of that interest or cease referrals by **October 1, 1994**.

The federal Stark statute has already gone into effect with respect to clinical laboratory services covered under Medicare, and will go into effect for other designated health care services covered under Medicare or Medicaid on **January 1, 1995**.

The author is an Assistant Attorney General with the Office of the Maryland Attorney General, Department of Health and Mental Hygiene Division. This article does not constitiute an official opinion of the Attorney General.

IT'S A LOT OF WORK. . .

One of the most important activities of the Board of Physician Quality Assurance is credentialling physicians and allied health practitioners for licensure. In fiscal year July 1, 1993 to June 30, 1994 there were 1,564 new licenses issued to physicians and 1,349 new licenses issued to allied health practitioners. Currently 20,790 physicians and doctors of osteopathy have active licensure in Maryland. Of these, 15,169 actually practice in the State. There are 561 interns and residents registered with the Board and 8,484 Allied Health Practitioners (physician assistants, psychiatrist assistants, cardiac rescue technicians, emergency medical technicians-paramedics, medical radiation technologists, nuclear medicine technologists, and respiratory care therapists) certified. The credentialling function of the Board is a lot of work! We hope physicians appreciated the shortened and simpler form used for renewal this year.

QUESTIONS ABOUT CME CREDITS

Q: Must I take CME in the area of my practice specialty?

A: No. While you are encouraged to participate in CME activities that are relevant to your field of practice, there is no requirement that the CME activities you engage in be related to your practice area.

Q: What about CME's if I have an inactive license?

A: Individuals who have an inactive license are not required to participate in CME activities during the course of their inactive period. However, the 50 documented Category I CME credit hours required for reinstatement must be obtained within two years of the application.

Q: Does an American Medical Association (AMA) Physician's Recognition Award (PRA) certificate satisfy the Board's CME requirements?

A: No, it does not. However, the Category I CME's used in part to obtain the Award are acceptable for reinstatement if earned within two years of the application.

Q: Which physicians will be required to have completed 50 Category I CME credits?

A: Physicians who are applying for reinstatement and physicians who will renew starting in 1995 are subject to the new CME requirement. Remember, physicians must retain CME documents for the succeeding six years for possible inspection by the Board.

NOTICE OF STATUTORY CHANGE

On October 1, 1994, new language has become effective for Section 14-404 (a) (34) of the Maryland Medical Practice Act: MD. HEALTH OCCUPATIONS ANN. CODE, §§14-401 et. seq. The new language authorizes disciplinary sanctions against the license of a physician who:

"Is in breach of a service obligation resulting from the applicant's or licensee's receipt of state or federal funding."

CLINICAL NOTE

by: Mary M. Newman, M.D.

PRESCRIBING FOR CHRONIC PAIN

From time to time the Board identifies a problem that has a high potential for disciplinary action. Dr. Mary Newman, a Board member since 1992 and a practicing internist in Baltimore County, has the following advice about prescribing for chronic pain.

Every year, the Board investigates and disciplines several physicians whose practices clearly violated the MD. HEALTH OCC. CODE ANN. §14-404 (a) (27) that states a licensee may be disciplined if he/she "Sells, prescribes, gives away, or administers drugs for illegal or illegitimate purposes."

BPQA frequently receives complaints from pharmacists, drug enforcement agencies, and consumers regarding the excessive prescribing of controlled or dangerous substances by physicians. The physician may find that there is a very fine line between the judicious relief of pain and the overuse or abuse of narcotics. Many physicians find the treatment of chronic pain to be particularly frustrating and difficult.

Physicians who keep accurate records, establish reasonable diagnoses, obtain prudent consultation, and know how to recognize prescription drug abuse, addiction, and diversion should feel comfortable in using narcotics for both acute and chronic pain when medically justified. Careless or casual prescription of these controlled substances can lead to disciplinary action against the physician and his/her license to practice.

Ilustrative Case

A nurse approached Dr. A and requested that he write a prescription for Dilaudid for her ailing relative who was terminally ill with cancer. Relating that the patient's pain was poorly controlled, she asked him to prescribe further narcotic analgesia. Based on his "long professional association" with the nurse, the doctor prescribed: DILAUDID 20 TABLETS.

The nurse approached Dr. B. She told Dr. B that her ailing relative needed pain medication but their regular doctor was out of town. Dr. B knew of the ailing relative, but had not seen her as a patient. "As a favor," Dr. B. prescribed: DILAUDID 15 TABLETS.

The nurse approached Dr. C who had taken care of the ailing relative prior to transferring her care to an oncologist. "As a matter of courtesy" Dr. C prescribed for the ailing relative on four separate occasions a total of: DILAUDID 420 TABLETS.

The nurse approached Dr. D who had once examined the ailing relative and referred her to another physician for ongoing care and treatment. Dr. D was told that the attending physician was supposed to have left a prescription before going out of town, but had failed to do so. "To keep the patient comfortable" Dr. D prescribed on four separate occasions a total of: DILAUDID 350 TABLETS.

The nurse approached Dr. E who was familiar with the cancer patient through discussion with the nurse and others. Although he had not seen the patient, he "did as he was asked" because he trusted the nurse and prescribed a total of: DILAUDID 1390 TABLETS.

The cancer patient died. The nurse continued to obtain and fill prescriptions for Dilaudid and was arrested by the Maryland State Police Drug Diversion Unit.

All of the doctors in the illustrative case failed to follow the simple rules that keep physicians out of trouble. The doctors didn't have a bona fide doctor-patient relationship. They didn't examine the patient. They didn't maintain a high index of suspicion that their prescriptions might be diverted for improper use. They didn't contact the doctor of record to coordinate their interventions and make him aware that the patient either had unaddressed needs or that perhaps "something else" was going on -- like drug diversion. Even if the patient had actually been the recipient of the medication prescribed, all the physicians described violated the Maryland Medical Practice Act and could be disciplined by the Board for their actions.

Some of the key elements which can lead to an adverse disciplinary action include the following:

1. The physician has minimal or no documentation of the prescription, the medical diagnosis, the number of pills to be dispensed, refills, or alternatives to such prescription.

2. The physician administers controlled and dangerous substances to many patients at their first visit for what seem to be minor illnesses.

3. The physician does not recognize drug addiction or diversion of drugs for street sale.

4. The physician sells prescriptions to individuals who are not patients of the physician. In some cases these individuals may be undercover police officers.

5. The physician prescribes controlled substances for himself or family members in the absence of any bona fide medical diagnosis or medical record.

Editor's Note: According to the Drug Enforcement Agency, hydromorphone (Dilaudid) is a "drug of choice" among drug abusers and commands a street price from $25 to $80 per dosage unit. Other drugs often diverted for illicit use include oxycodone (e.g., Percocet, Percodan) and the benzodiazepams (Valium, Xanax, Klonopin). Hydrocodone as an analgesic (e.g., Vicodin, Lortab) and as an antitussive (e.g, Hycodan, Tussionex) is often abused. The non-controlled muscle relaxant carisoprodol (Soma) may be used by abusers to enhance the effects of hydrocodone or alcohol; repeated requests for this drug should raise the consideration that substance abuse may be occurring.

BOARD ADVISORIES

EMERGENCY TELEPHONE PRESCRIBING OF CDS II

In emergency situations, pharmacists are authorized to dispense Schedule II drugs by telephone order from the physician. The amount of drug dispensed is to be limited to the amount adequate to treat the patient during the emergency period only. The physician is obligated to follow the telephone order with a written signed prescription labeled "Authorization for Emergency Dispensing" and either deliver the written prescription or mail it to the pharmacy to be postmarked within 72 hours of the oral request. Pharmacists are required to report physicians who fail to comply with this requirement by notifying the Division of Drug Control at 410-764-2890.

NEW ALTERNATIVE TO TEST OF SPOKEN ENGLISH

Applicants for Maryland licensure who attended medical schools in which English was not the language of instruction are required to take and pass the Test of Spoken English (TSE) with a score of at least 220 and Test of English as a Foreign Language (TOEFL), with a passing score of at least 550. Applicants who have never taken the TSE may take the Oral Proficiency Interview (OPI) administered by the American Council for the Teaching of Foreign Languages. The OPI can be taken at the BPQA office by telephone, by prior arrangement. The entire process, including scoring can be accomplished in approximately one week. Applicants who pass the OPI with a score of at least three will not have to take the TSE. The OPI costs $45 more than the TSE, but many applicants may find the speedier process well worth the additional cost if they wish to expedite their licensure application.

FILING A FALSE REPORT IN THE PRACTICE OF MEDICINE

The Board was recently asked to investigate a complaint that a physician certified a patient as being totally disabled when the doctor had never examined the patient. When asked how well he knew the patient, he admitted "not at all." The doctor rationalized that the $10 reimbursement allowed for completing the Evaluation of Impairment and Disability form for the Maryland Department of Human Resources did not compensate him for the time to examine the patient. On the other hand, if he failed to certify the patient as disabled, he believed that the patient would be unable to obtain State assistance, and thus be unable to afford a physical examination.

Certifying a patient as disabled and making a diagnosis to support the claim of disability requires that the doctor actually interview and examine the patient. If the physician deems the reimbursement offered for providing this service unacceptable, the doctor is not obligated to provide the service. But if he/she fills out any medical document, there is an obligation to do so accurately and honestly based on a bona fide interview and examination. Failure to abide by this warning can result in disciplinary action by the Board for making or filing a false report or record in the practice of medicine.

The Board will not accept financial considerations as an explanation to justify substandard care or false reports, records, or certifications.

NEW PHYSICIAN ASSISTANT FORMS

The Physician Assistant application for Initial Certification and the application for Approval of Job Description forms have been revised recently. Copies of the new forms may be obtained by calling the Board. Obsolete forms should be destroyed.

BOARD DISCIPLINARY ACTIONS JULY 1 - SEPTEMBER 30, 1994

CARTER, Thomas N., M.D., License #D01152. **License suspended.** The physician may petition for a stay of suspension provided he meets certain conditions which address competency in the practice of medicine. Effective 7/6/94.

MUIR, Edward A., Respiratory Care Practitioner, Certificate #L01830. **Surrender of certification because of an inability to work competently due to illness.** Effective 7/12/94.

COHEN, Melvin W., M.D., License #D17282. **License revoked.** Action taken pursuant to state statute which requires revocation of a license upon conviction, guilty plea or plea of nolo contendere with respect to a crime of moral turpitude. The physician was convicted of nine counts of knowingly and intentionally dispensing controlled dangerous substances in violation of 21 U.S.C. 841 (a) (1). Effective 7/19/94.

KELTON, Richard A., M.D., License #D45018. **License suspended; immediate stay; probation concurrent with a Board approved contract with the Physician Rehabilitation Program.** The physician violated a condition of a disposition agreement which dealt with the prohibition against the use of mood altering chemicals. Effective 7/26/94.

HAIRSTON, Ronald P., M.D., License #D07816. **License reinstated. Probation subject to terms and conditions.** The physician has complied with conditions which assessed his competency in his practice of general medicine. Effective 7/27/94.

FARZANFAR, Mohammad R., M.D., License #D04295. **Summary suspension.** The Board determined that there is a substantial risk of harm to current patients due to multiple complaints alleging inappropriate physical or sexual contact with the patients. Effective 7/27/94.

LEROY, Pierre L., M.D., License #D06533. **License revoked.** The Board determined that the physician was convicted of a crime of moral turpitude in connection with his pleas of nolo contendere to two counts of unlawful sexual contact, third degree in the State of Delaware. Effective 7/28/94.

TEUNIS, Bernard S., M.D., License #D14120. **Reprimand. Probation subject to conditions.** The physician admitted to engaging in an inappropriate relationship with a patient concurrent with a physician/patient relationship. Effective 8/9/94.

SHAMIM, Ahmad, M.D., License #D10243. **License reinstated. Probation for 3 years subject to conditions.** The physician has met the conditions precedent to the reinstatement of his license. Effective 8/16/94.

COLEMAN, Rita M., M.D., License #D15258. **License revoked.** The Board concluded that the physician is professionally, physically, or mentally incompetent. Effective 8/24/94.

COOPER, Thomas J., Medical Radiation Technologist. Certificate R01896. **Reprimand. Probation subject to conditions.** This health provider was found guilty of a crime involving moral turpitude which is a ground of discipline for medical radiation technologists in Maryland under COMAR 10.32.10.10 (21). The provider pled guilty to one count of bigamy in the Circuit Court for Anne Arundel County. Effective 8/24/94.

MESBAHI, Kathy, A., M.D., License #D28710. **Probation for 3 years subject to conditions.** The Board concluded that the physician failed to meet appropriate standards of care in her practice of obstetrics and gynecology. Effective 8/24/94.

ORTIZ, Armando, Medical Radiation Technologist., Certificate #R03901. **Applicant granted certification subject to condition that he notify the Board as to any change in employment.** The Board took action because the applicant failed to provide accurate information on his application for certification. Effective 8/24/94.

SARKISSIAN, Sarkis, M.D., License #D29316. **License reinstated. Probation 2 years.** The physician has met conditions precedent to reinstatement subject to conditions limiting the physician's practice to general gynecology on a part-time basis. Effective 8/24/94.

ROSS, Bradford A., M.D., License #D26689. **Surrender.** The decision to surrender his license was prompted by the physician's arrest on August 1, 1994 and subsequent charges of possession of a controlled dangerous substance (CDS), attempting to obtain CDS by forging a prescription and attempting to obtain CDS by uttering a false prescription. Effective 8/30/94.

CORNER, Michael F., Physician Assistant, Certificate #C651. **Certification reinstated, after completion and filing of all administrative documents.** The allied health provider shall not treat any individuals under 18 years of age. Effective 8/30/94.

AMAR, Leroy J., M.D., License #D17949. **Consent order of December 28, 1993 modified. Reinstatement of license upon completion of community service.** The reinstatement of licensure will be subject to further probation of 3 years. Effective 9/2/94.

SPAULDING, Michele D., M.D., License #P07718. **Surrender of registration.** Effective 9/2/94.

HODJATI, Hassan H., M.D., License #D23383. **Reprimand. Probation for 5 years subject to conditions.** The physician wrote prescriptions in the names of others for his own use. Effective 9/14/94.

GRECO, William R., M.D., License #D01485. **Probation terminated. The physician shall not practice medicine in Maryland until he appears before the Board and obtains the Board's approval.** The physician has complied with the current probationary period. Effective 9/20/94.

SMITH, Robert L., M.D., License #D24858. **Suspension; immediate stay; probation for 5 years subject to conditions.** The Board concluded that the physician was professionally incompetent, failed to meet standards of care and prescribed drugs for illegitimate medical purposes. Effective 9/20/94.

JACOBS, Harvey B., M.D., License #D17933. **Probation imposed by Board Order of 1981 terminated.** The physician is granted an inactive license and agrees to appear before the Board if he intends to resume the practice of medicine in Maryland. Effective 9/27/94.

WILLIAMS, Carter J., M.D., License #D27537. **License revoked.** The physician was convicted of medicaid fraud. The conviction was confirmed on appeal. The physician, therefore, falls within the mandate of Maryland statute that requires revocation of licensure for a crime involving moral turpitude. Effective 9/28/94.

THE MARYLAND MEDICAL PRACTICE ACT

To order a copy of the 1993 Edition of the Maryland Medical Practice Act, send a check or money order in the amount of $5.00 to the Board.

NEW BOARD MEMBER

Dr. William A. Crawley

BPQA welcomes William A. Crawley, D.D.S., M.D., the Board's newest member. Dr. Crawley received a degree in dentistry from Baylor College of Dentistry before obtaining his medical degree from the Johns Hopkins University School of Medicine. He completed fellowships in oral surgery, general surgery, and plastic surgery and is board certified by the American Board of Plastic Surgery. Dr. Crawley is an instructor of Plastic Surgery at the University of Maryland School of Medicine and associate professor of plastic surgery at the Johns Hopkins University. His hospital privileges include Johns Hopkins Hospital, the Children's Hospital, Greater Baltimore Medical Center, Saint Joseph Hospital, Union Memorial Hospital, and the Maryland Institute for Emergency Medical Services Systems. The Board looks forward to working with Dr. Crawley during his four-year appointment.

We welcome your input. If you have questions, comments, or suggestions for future topics for the BPQA Newsletter, contact Cheryl E. Winchell, M.D., c/o BPQA, 4201 Patterson Avenue, Baltimore, MD, 21215.

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